Dear: __________________________________________________________ Date: __________________________

Your youth __________________________________________________________ is a current resident at our facility. Attached are a few policies that are required to be shared with you.

**Medical Consent:** The BCJH contracts a registered nurse and doctor to review resident medications and to handle minor medical issues. The BCJH is required to provide a physical within 7 days of detainment unless there is a copy of a physical provided that had been completed in the last 10 months. The youth can request to see the nurse during medical clinic times. Please sign the attached request and return so that we may attend to your youth’s immediate medical needs. The nurse will contact the legal parent/guardian on file to discuss any changes in health status. If for any reason your youth needs to be transported to urgent care or the hospital you will be contacted as soon as possible.

**Prescriptions:** The staff understand that transportation to the BCJH may not always be convenient or possible. The BCJH utilizes Layerer’s Pharmacy. You may choose to have refills transferred to Layerer’s and let them know that the prescriptions need to be delivered to the Bay County Juvenile Home. You will need to provide insurance information and pay any co-pays.

Layerer’s Pharmacy
1100 Columbus Avenue
Bay City, MI 48708
989-893-7579

**Immunizations:** Immunization Clinic is the first Thursday of each month. The Bay County Health Department administers the immunizations at **no cost**. The registered nurse refers to the Official State of Michigan Immunization Record for each youth to determine the eligibility for immunizations. Immunizations available are Tdap, Hib, Polio, MMR, Hep B, Vericiella, Hep A, Flu, Pneumococcal Conjugate, Meningococcal Conjugate and HPV. Some of these vaccinations are a series. If the youth refuses the immunization we do not force the youth to receive them. The Health Department requires the attached consent to be completed. The BCJH is required to offer these immunizations for youth who remain in the facility after 29 days. If you have an up to date immunization record please fax or email to the BCJH. Fax # 989-892-4419 or email juvhome@baycounty.net. You may also give a copy of the record to the Probation Officer or DHHS caseworker to forward to the facility.

**Dental:** Dental services are provided by the Mobile Dental Bus. Consent forms attached. No cost to the parent. If there are costs there will be no services completed unless the cost is approved by the legal parent/guardian.

Thank you,

Bay County Juvenile Home
MEDICAL CONSENT AND AUTHORIZATION FORM

Resident Name: ____________________________ DOB: ____________________________

I hereby consent and authorize: Bay County Juvenile Home
520 West Hampton Road, Essexville, MI 48732
Phone: 989-892-4519 Fax: 989-892-4419
Email: juvhome@baycounty.net

To provide the following services for my child:

Any physical examination and/or appropriate medical care or treatment including hospital admittance, emergency treatment including surgery, dental care or mental health services to be provided by qualified medical personnel as deemed necessary to protect the health of my child. This consent and authorization includes the authorization for disclosure of my child’s complete health records as may be necessary to provide appropriate medical care and treatment and follow-up care. Initial ____________________________

It is understood that the Bay County Juvenile Home will make all reasonable efforts to notify me of any injury or emergency medical care or treatment that is necessary while my child is in the care and custody of the Bay County Juvenile Home. I understand I have the right to revoke this authorization at any time prior to disclosure by giving written notice to the Facility Director. Initial ____________________________

I consent to testing for infectious, contagious and sexually transmitted diseases including, but not limited to hepatitis, hepatitis B, HIV and AIDS in the event my child’s bodily fluid comes into contact with any volunteer, employee or resident of the BCJH. Results of that testing will be made available to the Director of the Bay County Juvenile Home. Initial ____________________________

Allergies of the youth:

Medical Insurance Information:

Parent/Guardian Signature: __________________________________________ Date: ___________

Printed Name: ______________________________________________________

Witness: __________________________________________ Date: ___________

520 West Hampton Road, Essexville, Michigan 48732
Tel: (989) 892-4519 Fax: (989) 892-4419 TDD (hearing impaired): 989-895-4049
Web: www.baycounty-mi.gov
THE DENTAL BUS IS COMING TO YOUR CHILD'S SCHOOL!

Great Lakes Bay
Health Centers
SMILES ARE EVERYWHERE
Mobile Dental Program
989-921-4393

Patient Name: ___________________________  Grade: __________  Teacher Name: ___________________________

Birth Date: ____/____/____  Gender:  □ Male  □ Female  Email Address: ___________________________

Address: ___________________________  City: ___________________________  Zip Code: ___________________________

Home Phone Number: ___________________________  Cell Phone Number: ___________________________

Race:  □ White  □ Black/African American  □ Native Hawaiian  □ American Indian/Alaska Native
   □ Asian  □ Other Pacific Islander  □ More than one race  □ Refuse to report

Are you Hispanic/Latino?:  □ Yes  □ No  □ Refuse to Report  Is English your primary language?:  □ Yes  □ No
Are you or a family member a Migrant or Seasonal Farmworker?:  □ Yes  □ No

Guardian Information
Name: ___________________________  Phone Number: ___________________________  Birthdate: ____/____/____  Relationship to Patient: ___________________________

Emergency Contact
Name: ___________________________  Phone Number: ___________________________  Relationship to Patient: ___________________________

Dental Insurance: ___________________________  Medical Insurance: ___________________________
Insurance ID #: ___________________________  Subscriber Birthdate: ____/____/____  Relationship to Patient: ___________________________
Subscriber Name: ___________________________  Employer: ___________________________

Our Federal Funding requires we ask income of all our patients. Your name/identity is not used in any of our reports.
This information also helps us determine if you qualify for our payment assistance program (Sliding Fee).

Household Income $_________________________  □ Weekly  □ Biweekly  □ Monthly  □ Annual

How many people in the household does this income support?: ______________

In order to qualify for a Sliding Fee, you must:
1. Complete the "Application for Sliding Fee Program" below.
2. Write all the names and ages of persons residing in the household. (Signature required)

Application for Sliding Fee Program

Total "Gross Annual" Household Income from all Sources: $_________________________
(including Wages, Social Security, Public Assistance, Unemployment, Pension Payments, Alimony, Child Support or Other Costs Income)

Name Persons Residing in Household  Age  Name Persons Residing in Household  Age

******Total Number of People in Household_________________________

I declare that this information relative to my total household income and family size as stated above is true and factual.

Head of Household/Authorized Person Name: ___________________________

Head of Household/Authorized Person Signature: ___________________________
Date: ____/____/____

Medical History (If you check Yes or No)

Allergies (other) type:  □ Yes  □ No  Asthma:  □ Yes  □ No  Seizures:  □ Yes  □ No
Allergies (medications):  □ Yes  □ No  Diabetes:  □ Yes  □ No  Other Medical Conditions/Medications: ___________________________
Heart Problems type:  □ Yes  □ No  Is pre-medications needed for dental procedures?:  □ Yes  □ No

By signing this consent form and selecting "YES" I certify that I am the legal guardian and legal custodian of the student named above. I give my consent for the above named student to receive all services, listed on the front of this consent form, provided by Great Lakes Bay Health Centers Mobile Dental Program. I understand that treatment may be obtained at the patient's dental home rather than the mobile dental facility and that obtaining duplicate services at a mobile dental facility may affect benefits that we or the patient receives from private insurance, a state or federal program, or other third-party provider of dental benefits. I authorize GLBHC's Mobile Dental Program to release information regarding treatment to third-party payers or others for the purpose of obtaining payment for services. I further authorize GLBHC and my child's dentist to exchange health care information for the purpose of continuity and coordination of care. By selecting "NO" and signing this form, my child will not be treated. I understand that I may withdraw my consent for services upon written notice to GLBHC's Dental Department at any time. Make sure to read and complete both sides of this form before signing.

□ Yes, I give permission to have my child receive dental treatment from GLBHC's Mobile Dental Program.

Patient/Guardian Name: ___________________________
Patient/Guardian Signature: ___________________________
Date: ____/____/____

□ No, I would not like my child to receive dental treatment from GLBHC's Mobile Dental Program.

Patient/Guardian Name: ___________________________
Patient/Guardian Signature: ___________________________
Date: ____/____/____
CLIENT CONSENT

CONSENT FOR CARE

I hereby voluntarily consent to authorized BCHD health care professionals including physicians, nurse practitioners, nurses, medical assistants, social workers, and employees of Bay County Health Department (BCHD) to perform services, procedures and/or treatments as prescribed by my physician or in accordance with BCHD specific program/clinic/service protocol.

I further authorize BCHD to obtain specimens of blood, urine, and other body fluids, tissues or products for the purpose of tests or procedures as deemed appropriate for my care. I realize that if tests are taken for sexually transmitted diseases, reporting positive test results to the Michigan Department of Health & Human services is required by law.

I authorize the use of photographs for the purpose of health care and documentation and transfer to BCHD all rights and interest in such photographs.

I have had the purpose of the program/service explained to me, want to participate, and have reviewed my plan of care (if applicable). I understand the services I am to receive, and understand I can withdraw from participation at any time.

CONSENT TO HIV TESTING

I understand that BCHD may perform an HIV, Hepatitis B and Hepatitis C test upon me without additional written consent in the event a BCHD health professional or designee has a percutaneous, mucous membrane, or open wound exposure to my blood or body fluids. The results of any test(s) will be treated confidentially, but may be disclosed as necessary for care of the health professional or designee at risk for blood borne pathogen infection due to exposure to my blood or body fluids.

CONSENT TO BILL

I request that payment of the authorized benefits from my health insurance be made on my behalf to BCHD. I certify that the Health insurance information I provided is accurate and correct. BCHD will accept payment from Medicare and Medicaid as full payment for covered services.

In the event the insurance company pays me directly, or if the service is not covered by my health insurance, I or my estate will be fully responsible for reimbursing BCHD.

☐ Services to be billed to my insurance
☐ Services to be billed to me

Bill: ☐ Medicare ☐ Medicaid ☐ Blue Cross/Blue Shield ☐ Other Insurance ☐ Sliding Fee Scale

CONSENT TO USE OR DISCLOSE HEALTH INFORMATION

I authorize BCHD to release by mail, phone, fax, or secure encrypted email and/or to obtain all or any portion of my or my child’s health record to or from hospitals, health care providers, insurance companies, service agencies, auditors or others involved in my or my child’s care that may be pertinent to the delivery, coordination and evaluation of my/my child’s care. This includes all information about my or my child’s status related to communicable diseases and infections, sexually transmitted infections (STI), Tuberculosis (TB), Hepatitis B, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), alcohol and drug abuse treatment information, mental health treatment records, psychological services and social services information including communications made by me to a social worker.

CONSENT & AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO OBTAIN PAYMENT

I authorize BCHD and its health care providers to release to any third party payor (Medicaid, Medicare, private health insurance etc.) and their clinical review agencies, or insurance carriers, welfare authority or other person or party responsible for any portion of care that is rendered to me such information from my health records as is required in order for BCHD to receive payment or reimbursement for my treatment, including alcohol, and drug abuse records protected under regulations in 42 Code of Federal Regulations, Part 2 (if any), psychological service records (if any), and social service records (if any). This consent shall be effective only so long as is necessary to obtain payment or retrospective authorization for payment and will expire when final payment has been received. This consent to release medical information is subject to revocation at any time with respect to any drug or alcohol abuse records, except to the extent the information has previously been released in reliance thereon.

This consent can be revoked by the client/client’s authorized representative at any time unless the agency has acted in reliance upon its continued effectiveness. Without expressed revocation this consent expires within one year, or (please check) ☐ until no longer enrolled in Children’s Special Health Care Services.

☐ I have received a copy of the Bay County Notice of Privacy Practices

I have read this consent form or it has been read to me and have had my questions answered to my satisfaction.

Signature of Client or Authorized Representative  Relationship  Date

Reason for signature of Authorized Representative (instead of Client Signature):

Signature of BCHD Representative  Date

RM 076  
Revised 10-18
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Insurance Type  
Card Holder Name:  
Card Holder Birth Date:  
Enrollee ID  
Group #  
Medicare #  
Medicaid #  

1. Are you allergic to eggs, thimerosal (preservative), latex, or have any other allergies?  
   □ Yes  □ No
2. Have you ever had an adverse reaction to a flu shot or any other vaccine?  
   □ Yes  □ No
3. Have you had Guillain-Barre syndrome within 6 weeks of a flu shot?  
   □ Yes  □ No
4. Are you sick today?  
   □ Yes  □ No
5. Have you had MMR, Varicella, Nasal Spray Flu or any other vaccines in the past 30 days?  
   □ Yes  □ No
6. Have you ever had a seizure or neurological problem?  
   □ Yes  □ No
7. Have you taken cortisone, prednisone, steroids, anticancer drugs, or x-ray in last 3 months?  
   □ Yes  □ No
8. Have you received a blood transfusion, plasma, or immune globulin in the last year?  
   □ Yes  □ No
9. Are you pregnant or is there a chance of becoming pregnant the next 3 months?  
   □ Yes  □ No
10. Do you have cancer, leukemia, AIDS, or any other immune system problem?  
    □ Yes  □ No
11. Did you receive the vaccine information sheet today?  
    □ Yes  □ No
12. Do you have any questions?

MCIR (Michigan Care Improvement Registry)
□ Yes, please register my or my child’s immunization history in the MCIR system.
□ No, I do not want my or my child’s immunization history registered in the MCIR system.

SIGNATURE ____________________________  Legal Guardian Name: ____________________________

For Office Use Only
□CPOX Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□DTAP Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□FLU Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□HEP A Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□HEP B Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□HIB Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□HPV Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□KINRIX Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□MENACWY Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□MEN B Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□MMR Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□MRV Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□PCV13 Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□PEPIARIX Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□PPSV23 Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□POLIO Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□ROTA Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□SHINGRIX Lot # Site  Manuf.  Eligibility $ or VFC or AVP
□TDAP Lot # Site  Manuf.  Eligibility $ or VFC or AVP

Nurse Signature ____________________________
Dear Parent or Guardian:

It is required that the Bay County Juvenile Home provide each parent/guardian with a copy of the grievance policy and the policy for resident restraints. It is requested that you initial and sign below indicating that you have received each policy. This form will be renewed yearly when applicable.

Resident Name: ____________________________________________

_____ Initial regarding grievance policy

_____ Initial regarding restraint policy

Your signature verifies that you have received a copy of the policies noted above. You understand that if you have questions or concerns you may speak with a Supervisor or the Director.

For further questions or concerns I may contact:

Supervisor Joe Beauchamp (2pm – 10 pm T-F and 12pm -8pm Sat)
Director Juli Reynolds (8-5 M-F)

Signature:__________________________________________ Date:_______

Print name: ____________________________________________

Relationship to youth:______________________________

Scan this paper into the resident’s file and give to parent/guardian
Policy

Upon admission to the BCJH, all youth shall be informed of their right to file grievances against any behavior or disciplinary action of staff or other youth in the facility. Grievances that have not been resolved informally shall be filed according to the procedures outlined below. All youth grievances shall be handled expeditiously and without reprisal against the grievant.

YDW and Supervisors who have contact with the parents/guardians and referral sources shall provide a copy of this policy prior to admission, at admission or if necessary after admission. Written acknowledgement must be attempted whenever possible that this policy was made available. If written acknowledgement cannot be attained a note in the resident’s file stating the policy was given to the parent/guardian or referral source will suffice noting date and time given. This will be documented under the tab “Notes” in the file.

This grievance policy shall be made available to residents, parent/guardians and referral agents. An interpreter shall be sought when necessary.

For any allegations by a youth for lack of medical attention or abusive conduct see Detention Policies: Monitoring and Reporting Abuse & Neglect

Informal resolution: All residents are encouraged to resolve grievances informally with staff. In most instances, a discussion between the resident and staff will result in a satisfactory solution. The staff member shall note the informal discussion in the resident’s progress notes. It is not mandatory for residents to attempt to resolve complaints informally. If a resident is not satisfied with the discussion and result of the conversation, the youth may utilize step I of the grievance process. Residents may submit any grievance in a sealed envelope labeled Supervisor.

Grievance Forms: Grievance forms and envelopes are available in the South dayroom. Residents may retrieve the forms as needed however must ask for permission to get up and request a pencil. If the timing is not appropriate the YDW shall notify the resident and allow the resident to retrieve a grievance form at a later time during the shift. Morning or afternoon bathroom break during school would be an appropriate time.

Resident Grievance Process:

Step I: The resident may complete a grievance in writing to the Supervisor if the Supervisor is not involved in the grievance. If the Supervisor is not present the resident may complete the grievance and seal in an envelope. The envelope can be placed under the Supervisor's office door.
The resident is to place the grievance in writing noting information directly related to the incident. Include date and approximate time of the incident.

The Supervisor will obtain information regarding the situation, discuss the situation with the resident objectively, and render a decision within 3 business days.

When the Supervisor responds to a grievance the following shall be completed

- A written response to the grievant shall be completed on the original grievance form with additional sheets of paper attached as needed.
- Original form and attachments shall be given back to the resident
- A copy of the form and response shall be given to the Administrative Supervisor.
- The copy shall be filed in the Administrative Supervisor’s office under resident grievances.

If the grievance involves the Supervisor or if the resident is not satisfied with the decision of the Supervisor, the resident may proceed to Step II within 3 days.

**Step II:** If the resident is not satisfied with the response in Step I the grievance may be submitted to the Director by placing the grievance in a sealed envelope in the Director’s mailbox. The Director will review all pertinent information and conduct necessary interviews. The Director will respond to the grievance within 5 business days of receipt of the grievance. The Director’s response is final.

**Complaints or Concerns from resident’s parent/guardians:** If the parent/guardian has concerns regarding the wellbeing of the resident the parent may address it verbally with the Supervisor. For any allegations by a youth for lack of medical attention or inappropriate conduct see Detention Policies: Monitoring and Reporting Abuse & Neglect

The Team Leader will provide writing materials for the parent/guardian to complete a grievance in writing or inform the parent/guardian to call the Administrative Supervisor directly to discuss further.

The administrative supervisor shall contact the grievant and initiate an investigation. The Administrative Supervisor will respond in writing to the parent/guardian within 4 business days of receipt of complaint.
All complaints and grievances to the Supervisor or Director should be sealed by the grievant. The grievant should write Supervisor across the seal.

Retraction: If the resident, parent or guardian chooses to retract the grievance this shall be allowed if the grievant makes this request in writing. Submit the retraction in the Supervisor’s mailbox. Staff are not to take the grievance out of the Supervisor mailbox. The Supervisor will file the grievance with the retraction in the grievance file.

Provide this policy for residents, their families and referring sources prior to or at admission. Written acknowledgement must be obtained that this policy was provided. If parent/guardian to enter the facility by the first visiting session of the youth entering the facility a copy of this grievance will be mailed to the parent/guardian.

When it is appropriate an interpreter shall be made available to translate this policy to the resident and/or resident’s family.
Policy
R 400.4159 Resident Restraint – This policy applies to all employees of the Bay County Juvenile Home. This policy shall be made available to all residents, their families, and referring agencies.

Emergency Safety Physical Interventions (ESPIs) shall be performed in a manner that is safe, appropriate, and proportionate to the severity of the minor child’s behavior, chronological and developmental age, size, gender, physical condition, medical condition, also considering any known psychiatric condition, and personal history, including any known history of trauma.

All Youth Development Workers shall be trained in Safe Crisis Management (SCM) yearly by someone who is certified in training the SCM Theory and Techniques. Employees, Interns, Teachers etc. in the facility may only utilize ESPI techniques on residents after the individual has completed and passed the SCM training. The exception would be for Law Enforcement when called into the facility for assistance in maintaining control.

All ESPIs shall be reported to the Director and the incident will be reviewed within 48 hours by a level of supervision above the staff ordering or conducting the restraint to determine if the requirements of these policies have been adhered to in directing and conducting the restraint.

ESPI or Mechanical restraints are to be used as a last resort when less restrictive discipline and/or behavior management has been unsuccessful.

The Director or designee shall review all restraints at a minimum of every 6 months.

Definitions
Emergency Safety Physical Intervention (Physical restraint) – Restricting a resident’s movements physically utilizing techniques learned from Safe Crisis Management Training.

Mechanical Restraint – Restraining a resident utilizing hand cuffs, ankle shackles and/or waist cuffs.

Procedure
ESPIs physical or mechanical are only permitted under the following circumstances

- To prevent injury to the resident, or injury to others
- As a precaution against escape or truancy
- When there is serious destruction of property that places a resident or others at serious threat of violence or injury if no intervention occurs.

ESPI techniques shall not be used for punishment, discipline or retaliation

The use of a restraint chair is prohibited
The ESPI shall only be applied for the minimum time necessary to accomplish the purpose for its use. Approval of the Supervisor (in the absence of the Supervisor the Team Leader) shall be obtained when the ESPI lasts more than 20 minutes.

The approval of the Supervisor or Team Leader shall be obtained prior to any use of mechanical restraints. A staff member shall be present continuously while material or mechanical restraint equipment is being used on a resident, and the staff member shall remain in close enough proximity to the restraint to intervene immediately in case of emergency to protect the safety of the resident. Residents in restraints are to be monitored directly and not remotely by camera or through glass.

Each use of an ESPI and/or mechanical restraint equipment shall be documented in a written record (incident report in YouthCenter) and shall include all of the following information:

- The name of the resident (this will be evident when completing in YouthCenter)
- The name of the supervisor or Team Leader who authorized the use of the equipment, and the time of the authorization
- Time the restraint was applied
- The name of the staff member who was responsible for the application
- A description of the specific behavior that necessitated its use and de-escalation tactics attempted prior to the ESPI or mechanical restraint.
- The name of the staff person who was continuously with the resident for mechanical restraints
- The date and time of removal of the restraint and the name of the person removing the equipment
- All staff involved in the ESPI will complete a narrative in the same incident report.
- If the report is sent back to the employee for more information it will be completed and returned within 24 hours.

The following is prohibited:
- The use of noxious substances
- The use of instruments causing temporary incapacitation
- Chemical restraints
- The use of ESPIs or mechanical restraints for punishment, discipline or retaliation.

After release from a physical intervention staff must:
1. Check for injury to resident. Document that the resident has been checked for injury and what injuries occurred.
2. Aid resident in basic first aid when situation is under control. Document the need for first aid and what was administered. Complete an injury report.
3. If further medical treatment is necessary follow emergency medical procedures
4. Complete an injury report for nurse review even if the resident states no injuries.
5. Monitor the resident for the next few days for any missed injury. If resident has bruises or injury as a result in the next few days document as an edit in the original report and complete a new progress report discussing injuries discovered.

Debrief: The purpose of the debriefing is to review the incident with the resident and see the situation through the resident’s view. The resident will also be present to discuss the situation from the YDW’s view.

1. Allow resident some quiet time to process the situation internally.
2. Listen to the resident’s version. When the resident is finished the YDW will describe the behavior that was observed. Describe the behavior without demeaning the resident.

Physical transport: moving the individual from one area of the facility to another as the individual is not willing to move voluntarily.

1. **The only approved method to utilize is the hook transport and only if the resident will walk.** This method does not allow for staff to engage in a physical intervention with a youth without the youth being a danger of harm to himself or others as listed above.
2. **At no time shall the resident be pushed, dragged, pulled or carried by Juvenile Home staff from point A to point B.**